REVIEWS OF BOOKS.

CURE RADICALE DES HERNIES. Par le Dr. JUST LUCAS-CHAMPIONNIERE, Chirurgien de l' Hôpital Tenon, etc. Paris: Adrian Delahaye et 'Emile Lecrosnier, 1887.

ON THE RADICAL CURE OF HERNIA. By Dr. JUST LUCAS-CHAMPIONNIÈRE, Surgeon to the Hospital Tenon, etc. Paris.

To Dr. Lucas-Championnière has been ascribed the merit of being "the introducer of antiseptic surgery into France." He has been and is certainly its most active and enthusiastic apostle in that country, which, although the birthplace of Pasteur, has been slow to adopt the methods of Lister.

For Lucas-Championnière there is but one method of radical cure for hernia, the principles of which are unvarying, though the practice is to be minutely adapted to the circumstances of each case. That method is excision of the sac and suture of its neck.

This teaching is "*thorough*." There is to be no hurry, no incompleteness, and this applies equally to the mechanical execution of the operation and to the preservation of strict antisepsis. The mere statement of this should be enough to win for Dr. Lucas-Championnière and his teaching the sympathy of every surgeon of experience in the cure of hernia by excision of the sac. Truly, in this operation half measures are an utter delusion. The surgeon who, finding difficult the separation of the sac from its surroundings or from its contents, gives up the attempt, generally gives up the chance of securing a radical cure, and but trifles with the case by such proceedings as tying or sewing up a stump of omentum in the neck of the sac. Our author is very vigorous and clear on this point.

But in certain cases he would permit the operation to be divided into two parts, done on separate occasions. For example, in a case with an immense sac, he would not always dissect away and excise the whole sac at the same operation in which he cut it from its neck and tied the latter.

He considers that adhesion of omentum to the neck of the sac is a frequent cause of difficulty in retaining herniæ by a truss.

Unreduced testicles he regards as worse than useless and excises them remorselessly when associated with hernia. For their worthlessness he quotes Godart as his authority. But if, as our author emphatically states, an unreduced testicle is not only totally without sexual value, but also "a source of constant pain and a permanent menace of the return of the hernia," it is scarcely logical to require as a condition of its removal that the other testicle shall be healthy. This our author does, and suggests thereby that his conscience is not quite easy on the subject. For our part, we object to unrestrained castration and fail to see that the healthiness of the other testicle has anything to do with it. It is entirely a question of what the testicle to be removed is worth. Moreover, it should not be forgotten that a testicle has also a psychical value, so to speak.

Upon one occasion Dr. Lucas-Championnière, while operating for radical cure of hernia, wounded the vas deferens. He says: "I did not hesitate to practise castration simultaneously with the radical cure." He does not say exactly what he was doing when he wounded the vas deferens. Was he doing one of those extremely thorough and minute dissections of the sac which he recommends? Probably so. We also recommend the same, but recognize the obligation to point out that the procedure is surrounded by real dangers, especially to operators who affect "dash." We have seen a surgeon divide the vas deferens accidentally, and once had the misfortune to be assisted by a gentleman who fussily tore the vas deferens from all its connections for a distance of two inches before he could be stopped, thereby gravely imperilling both the vas and the testicle.

Occasionally, the difficulties of completely detaching the sac are very great. At his tenth operation, Lucas-Championnière says they were such that he would have been quite vanquished had it been his first and he, consequently, inexperienced.

He recommends the anæsthesia to be profound. Otherwise, the operator will be disturbed by impulse of the intestines or escape of blood. The minute dissection should be made while the parts are quiet and, after a fashion, bloodless.

In ligaturing the neck of the sac, and suturing the canal, Reverdin's needles are highly praised. These permit the eye of the needle (situated near its point) to be opened and shut by a slot moved by a button placed on the shank near the handle.

When the sac is very large, several ligatures are used, so passed

that they form a chain, each link of which both intertwines with its neighbor and pierces the sac. Illustrations are used to describe this.

The author regards the pillars of the inguinal canal as playing only a passive part, and their suture as only useful indirectly, even if useful at all.

What is to be desired, and, if necessary, buried sutures of catgut used to obtain it, is the fusion of raw surfaces and above all of the cellular tissue which joins all the parts together. Energetic compression (by the dressings) is strongly recommended in order to secure this.

He says that cicatrices formed without suppuration give a more perfect resistance than those formed after suppuration. The proofs furnished of this statement do not seem to us to be very strong, though we are inclined to believe that it is true.

Two interesting cases with large hernial apertures are described in which M. Lucas-Championniere transplanted skin to close up the apertures or help to do it. They appear to have been successful.

In one case a needle was broken and the point lost in the peritoneal cavity. The patient was seen some years afterwards quite well.

Our author prepares his own catgut.

Regarding the omentum as an active agent in the causation of hernia, he excises as much of it as possible. It is necessary to tie the knots very carefully in ligaturing omentum, as, the stump having to be passed back into the abdomen through a very narrow orifice, the ligatures are in danger of being rubbed out of place in the passage. When dealing with a mass of omentum, he divides it into several separate parts and ties each independently, not interlocking the ligatures into one chain, as he does when tying the neck of the sac. The result is that the omental stump does not form a great mass, difficult to return into the abdomen, but goes back easily and spreads itself out when returned.

With regard to drainage tubes they should only be superficial, and are not necessary in dealing with umbilical hernia, just as they are not necessary after ovariotomy.

We are inclined to take exception to this teaching. We believe that it is a mistake not to drain the superficial parts of some deep wounds. We have seen, for want of it, suppuration between the layers of the abdominal wall after an ovariotomy, between the aponeurosis and the skin after suture of the patella and other analagous accidents, which though perhaps not serious in themselves, have both alarmed and confused the surgeon.

He brings out the drainage tubes as far away from the genitalia as possible.

In order to do this, the reviewer has sometimes made a special opening for the tube and completely closed the original wound. This plan is to be particularly recommended after operating on large femoral herniæ in fat women with a deep sulcus at the groin.

In the chapter on "Dressing and Antisepsis" are made the following remarks, well worthy of consideration: "The operation presents numerous perils for antisepsis. The locality, the mobility of the dressing, the movements of the patient which tend to displace it, the uncleanliness or rather the habitual septicity of the region form serious obstacles to surmount. There may even be added to these difficulties what seems paradoxical, the simplicity and success of a large number of operations for strangulated hernia. In fact, as, after operation for strangulated hernia, the operation wound presents but a small surface, whilst the discharge is very moderare in quantity, repair takes place very satisfactorily or nearly so. Therefore, the surgeon concludes that the array of antiseptic precautions recommended to him is useless, he proceeds more quickly, more brilliantly, cures the three first patients operated on, loses the fourth and declares that the operation is dangerous in itself, for in truth he does not know why the last patient has perished and the other three survived. It is not the operation, it is *he* who is dangerous from confidence in imperfect procedures against which we have vainly sought to forewarn him."

This is exceedingly plausible, but the admissions of the real difficulties of applying antiseptic surgery in this operation contained in the beginning of the above quotation refute the assertion made at the end. What M. Lucas-Championniere states as *the* cause, the sole cause of failure, is only one of several, perhaps many, though we admit it is a very important one. The patient has not only to be carefully guarded against germs, but he has to be protected against himself, and, in the present state of education as regards the question, only too often against his dresser, his house surgeon and his nurse. No one could possibly be more careful than the writer of this review has always been about making his dressings "snug" and securing them in place, by the free use of rubber bandages and of strapping; and yet I one day found one of my hernia cases with his hands thrust beneath his dressings as if they were his breeches' pockets. This would have mattered nothing had he merely been operated on by injection. It is for practical purposes, perfectly idle to speak of an operation as if it were an abstract affair. One calls to mind a comparison of Ruskin's, and is reminded of a system of gymnastics based on the supposition that human beings have no skeletons and recommending men to roll them-

selves up into balls, tie themselves into knots, etc. But human beings *have* skeletons, and all the persons concerned in an operation for radical cure of hernia, patient, surgeons, assistants, nurse, each and all have frailties, are liable to forget, to mistake, to overlook, to overdo. Therefore, such an operation as that which M. Lucas-Championniere deals with, and of which in his book he only records ten observations of his own, must be dangerous in proportion as it is long, elaborate, complicated and tedious, requiring many instruments—animate and inanimate.

Returning to operative details, the site of operation is, as a preliminary, washed with "eau de Panama (decoction of Quillaya saponaria)." It is then washed with soap and a 1-20 carbolic lotion, and shaved carefully. After the shaving, it is rewashed with the 1-20 carbolic, and lastly covered with compresses soaked in 1-40, whilst the patient is being chloroformed.

The spray is used, and strong preference expressed for a producer made by Collin, of which the spray is extremely divided. The principle on which Lucas-Championniere uses the spray for these operations is that of using it for all cases in which a cavity is opened whose inmost recesses are inaccessible (during the operation in question).

Importance is attached to the association of several antiseptics. He washes the wound with both carbolic and sublimate lotions.

He sometimes uses "protective." In these regions where the wound can never be far from one edge of the dressings, is not protective objectionable from its directing any discharge towards the edges? For this reason the reviewer prefers iodoform gauze which answers every purpose and is more easily removed than sublimate or carbolic or glass-wool, because it is softer and more prone to absorb lotions.

Our author bandages a wet sponge over the first dressings, which are very composite, containing about seven different antiseptics. He covers all with a mackintosh. Our objection to this complicated dressing is that it is surely not necessary either for obtaining antisepsis or elastic support. All the details of dressings are described and rules for changing given very minutely. They are excellent but might be a little simpler.

M. Lucas-Championniere often places an inverted basin or a pile of books beneath the sacrum while bandaging.

With regard to the state of the parts some period after the operation he notes at first that the hernial canal is distended by a kind of "stopper" (bouchon), which afterwards dwindles to a fibrous cord, the canal itself contracting with it.

He recommends after the operation that a truss be worn, and especially a truss with a pad made to control the whole site of the operation. An illustration is used to describe this.

For our part, we believe that the point to be seen to is not the shape of the truss but its fit. We should be a little unhappy if we thought it essential to always send to M. Collin for spray-producers and to M. Rainal for trusses.

The book concludes with detailed accounts of ten operations by the author, of which nine were successful and found to remain so for periods varying up to as long as five years in one case. "No accidents were observed in any of the cases."

Our notice, broken up as it were, into fragments, conveys no idea of the completeness and finish of this excellent book. The young surgeon ambitious to commence the practice of the operation described, will not find in any language a safer or more useful guide. This notice must have demonstrated that it contains much to interest surgeons whose experience equals or exceeds that of M. Lucas-Championniere. And, throughout, the book is remarkable for its calm and judicial tone. The thoroughness and antiseptic enthusiasm which pervades every page never tempts our author into the slightest wilful exaggeration. After the fashion of the best French works, everything stated is given with precision and in due order. The form and arrangement of the monograph fit it to serve as a model. C. B. KEETLEY.

L'AMPUTATION DU MEMBRE SUPERIEURE DANS LA CONTIGUITE DU TRONC. (L'AMPUTATION INTERSCAPULO-THORACIQUE). Par PAUL BERGER, Chirurgien l'Hôpital Tenon, Professor Agrégé a la Faculté de Medicine, Membre de la Societe de Chirurgie. G. Masson: Paris, 1887.

INTERSCAPULO-THORACIC AMPUTATION OF THE UPPER EXTREMITY. By PAUL BERGER. Paris: 1887.

This work is based on the author's paper last year before the French Surgical Congress (v. ANNALS, 1887, April, pp. 346-8). The operation in question consists of total ablation of scapula and arm, resp. in some cases of whatever was left by previous amputation or accidental mutilation. This also ordinarily involves removal of the external or even greater part of the clavicle. It is not exactly either an amputation or a disarticulation, and has no counterpart on the lower extremity. Although repeatedly practised it does not seem to have any recognized position as an operation.

Since Cheselden's work in the last century it has been known that